Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS COUNTY HOSPITAL
P O BOX 660599
DALLAS TX 75235 7708

Carrier's Austin Representative Box
01

Respondent Name
LIBERTY INSURANCE CORP

MFDR Date Received
MARCH 13, 2012

MFDR Tracking Number
M4-12-2367-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the *Table of Disputed Services*: "the carrier request that we change codes on the bill for lower paye"

Amount in Dispute: $269,397.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary taken from Letter to Requestor dated December 29, 2011: "Your bill for the above-referenced claimant in the amount of $269,397.65 has been received. This was denied X045 (PLEASE RESUBMIT WITH A VALID DRG CODE FOR RECONSIDERAITON. PLEASE SUBMIT APPEAL WITH EOP AND BILLING FORM WITH VALID DRG CODE) as the ICD rules of proper sequencing were not followed on this claim. This had led to an error in the billed DRG."

Response Submitted by: Liberty Mutual, 303 Jesse Jewell Parkway SE, Suite 500, Gainesville, GA 30501

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 4, 2011 To September 8, 2011	Inpatient Hospital Surgical Services	$269,397.65	$86,910.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for

inpatient services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 6, 2011
   - X045 – Carrier did not define this denial reason code on the EOB.
   - U301 – Carrier did not define this denial reason code on the EOB.

   Explanation of benefits letter dated December 29, 2011
   - X045 –PLEASE RESUBMIT WITH A VALID DRG CODE FOR RECONSIDERATION PLEASE SUBMIT APPEAL WITH EOP AND BILLING FORM WITH VALID DRG CODE as the as the ICD rules of proper sequencing were not followed on this claim. This had led to an error in the billed DRG.
   - U301 – Carrier did not define this denial reason code on the EOB.

   Explanation of benefits letter dated February 14, 2012
   - X045 –Carrier did not define this denial reason code on the EOB.

Issues

1. Is DRG 856 valid'?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The respondent denied reimbursement based upon their assertion that the claim/service was billed with an invalid/incorrect DRG code. The requestor billed using DRG 856, "Postoperative or Posttraumatic Infections with O.R. Procedure with MMC" with a principal diagnosis of 958.3 Posttraumatic wound infections not elsewhere classified. The ICD (International Classification of Diseases) Diagnosis code in dispute is 958.3. ICD (International Classification of Diseases) Diagnosis code is 958.3 listed as MCC (major complications/comorbiity) in the 2011 DRG code book. The correct ICD (International Classification of Diseases) Diagnosis code is 958.3. Review of the requestors submitted admission/registration summary dated August 4, 2011 states, "Admit DX/Chief complaint: posttraumatic wound infection." Review of the requestors submitted Consent to Operation or Other Procedure form states, "left leg wound infection." Review of the requestors submitted Consent for Anesthesia and Sedation form states, "Left leg irrigation and debridement/wound vac placement". The division finds that the assertion by the requestor that the DRG is 856 is the correct code is supported. The division finds that the assertion of the respondent that the requestor billed using an invalid/incorrect DRG code is not supported nor did the respondent submit documentation to support that the requestor billed using an invalid/incorrect DRG code. For this reason, the division finds that the X045 claim adjustment code is not supported. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
3. 28 Texas Administrative Code §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is DRG 856, and that the services were provided at Dallas County Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $60,776.71. This amount multiplied by 143% results in a MAR of $86,910.70.
4. The division concludes that the total allowable reimbursement for the services in dispute is $86,910.70. The

respondent issued payment in the amount of $0.00. Based upon the documentation submitted reimbursement in the amount of $86,910.70 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $86,910.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $86,910.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		December 14, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		December 14, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.